STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN VILLAGE	2026 E 54TH ST INDIANAPOLIS, IN 46220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This survey was done in conjunction with the Investigation of Complaint IN00139191. Complaint IN00139191- Substantiated. No deficiencies related to the allegation(s) are cited. Survey Dates: November 6, 7, 8, 12, 13, & 14, 2013 Facility number: 000189 Provider number: 155292 AIM number: 100267330 Survey team: Lora Brettnacher, RN-TC Jeanna King, RN Karen Hartman, RN Census bed type: SNF/NF: 141 Residential: 72 Total: 213 Census payor type: Medicare: 30 Medicaid: 76 Other: 107 Total: 213 Residential sample: 7 American Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Recertification and State Licensure Survey and in regard to the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155292	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Investigation of Complaint IN00139191. Quality review completed 11/15/2013 by Brenda Marshall Nunan, R.N.	F 000		